



First Name

Middle Initial

WellDyneRx Prescription Drug Claim Form

INSTRUCTIONS:

EMPLOYEE INFORMATION

Employer's Name

- 1. Fill out all of the information on the claim form as completely as possible.
- 2. Please complete a separate claim form for each family member.
- 3. Please include the original receipt with prescription details from your pharmacy when submitting the WellDyneRx Prescription Claim Form. Cash register tape and photocopies will not be accepted.
- 4. If necessary, contact the pharmacist to provide the detailed drug information requested on the form for the prescription(s) dispensed.
- 5. Please provide the complete name, address and telephone number of the pharmacy. Should you or the pharmacist have questions regarding the completion of this form, please call our toll-free number at 855-799-6831. We are available 24 hours a day, 7 days a week.
- 6. Claim must be filed within 365 days of the date the prescription was filled.
- 7. Mail the completed form and original receipts directly to:

WELLDYNERX ATTN: Suffolk County Paper Claims PO BOX 90369 Lakeland, FL 33804

WDRXGRP#

8. You will receive a response within 30 days.

Use this form to be reimbursed for each prescription that you purchased without your prescription card. You will be reimbursed the network pharmacy rates, minus co-pays.

PATIENT INFORMATION

Patient's Last Name

1 - 7										
Last Name	First Na	me	Middle Initial	Birthdate (m/d/y):	/	/			
Identification Number				Male 🗖	Male □			Female		
Address										
City State Zip Code			Patient's Relationship to Employee							
City	ار		Zip Code	Self □	☐ Spouse ☐			Other 🗆		
Daytime Phone	Number									
PRESCRIPTION #1 INFORMATION				PRESCRIPTION #2 INFORMATION						
Rx Number		Date Filled		Rx Number	Rx Number D		Date Filled			
Quantity	Days Supply	, Ar	nount Paid	Quantity	Days Sup	ply	Amount Paid			
Prescribing Doctor DEA Number or Name				Prescribing Doctor DEA Number or Name						
Medication Name and Strength (mg., ml., etc.)				Medication Name and Strength (mg., ml., etc.)						
NDC Number:				NDC Number:						
Is this Drug: (Ch	eck All That Ap	ply)		Is this Drug: (Cl	neck All That	Apply)				
□ New Pres	scription [□ New Prescription □ Refill								
□ Compoun	nd Rx	Allergy Inje	ectable	□ Compound	Rx	☐ Allerg	y Injectal	ole		

PRESCRIPTION #3 INFORMATION					PRESCRIPTION #4 INFORMATION					
		Date Filled			Rx Number		Date Filled			
Quantity	Days S	upply	Amount Paid	Qua	antity	Days Su	ipply	Amount Paid		
Prescribing Doctor DEA Number or Name					Prescribing Doctor DEA Number or Name					
Medication Name and Strength (mg., ml., etc.)					Medication Name and Strength (mg., ml., etc.)					
and the same time time gar (right, mily										
NDC Number:				ND	NDC Number:					
				┥						
Is the Drug: (Check All That Apply)					Is the Drug: (Check All That Apply)					
☐ New Prescription ☐ Refill					□ New Prescription □ Refill					
☐ Compound Rx		☐ Allergy I	niectable		Compound Rx		☐ Aller	gy Injectable		
Compound tx		- Allergy I	пронаме		Joinpouriu IXX		<u> </u>	gy injectable		
PRESCRIPTION #5 INFORMATION					PRESCRIPTION #6 INFORMATION					
Rx Number Date Filled					Number		Date Filled	t l		
Quantity	Days S	upply	Amount Paid	Qua	antity	Days S	upply	Amount Paid		
Prescribing Doctor DEA Number or Name					Prescribing Doctor DEA Number or Name					
Medication Name and Strength (mg., ml., etc.)				Med	Medication Name and Strength (mg., ml., etc.)					
							-			
NDC Number:					NDC Number:					
Lo the Drugg (Check All That Apply)										
Is the Drug: (Check All That Apply)					Is the Drug: (Check All That Apply)					
☐ New Prescription ☐ Refill					New Prescripti	on	☐ Refi	II		
☐ Compound Rx ☐ Allergy Injectable ☐ Compound Rx ☐ Allergy Injectable								rgy Injectable		
_ Compound tx		— / mergy m	joolabio		Compound IX		- Allei	gy injudiable		
Pharmacy Name	9	Address	. (City	Sta	ite		Zip Code		
Pharmacy Telephone Number					NPI Number					
I certify that the info	rmation o	on this claim fo	orm is correct and au	uthorize re	lease of all info	rmation to	WellDyneF	Rx and the Plan		
I certify that the information on this claim form is correct and authorize release of all information to WellDyneRx and the Plan Sponsor. I also certify that the patient for whom this claim is made is eligible for benefits and does not have primary prescription drug										
coverage under any other group medical plan. I verify that the drugs listed are not for treatment of an occupational injury or disease for which the Employer has accepted liability.										
This form must be signed:										
			Employe	ee/Membe	er's Signature			Date		